

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF HISTORY REGARDING HEADACHES**

*Form Approved  
OMB No. 0704-0396  
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The public reporting burden for this collection of information is estimated to average 7 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0396), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO DODMERB/DR, 8034 EDGERTON DRIVE, SUITE 132, USAF ACADEMY CO 80840-2200.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397.

**PRINCIPAL PURPOSE:** To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

**ROUTINE USES:** This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applications to their Academies.

**DISCLOSURE:** Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

**INSTRUCTIONS**

Please provide the following information concerning your history of headaches. Be very specific in your answers. If additional space is needed, please use the reverse side of this form.

**1. HOW OFTEN DO YOUR HEADACHES OCCUR?** *(e.g., monthly, quarterly, every six months, etc.)*

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**2. WHEN HEADACHES OCCUR, WHAT IS THEIR FREQUENCY?** *(e.g., once a day, twice, three times, etc.)*

\_\_\_\_\_

**3. HOW LONG DO THE HEADACHES USUALLY LAST?** *(e.g., 1 hour, 2 hours, 6 hours, etc.)*

\_\_\_\_\_

**4. HAVE YOU EVER TAKEN ANY MEDICATIONS FOR YOUR HEADACHES? IF SO, PLEASE EXPLAIN IN DETAIL** *(e.g., what medication, usual dose, etc.)*

\_\_\_\_\_

\_\_\_\_\_

**5. DO HEADACHES INTERFERE WITH NORMAL ACTIVITIES?**

\_\_\_\_\_

\_\_\_\_\_

**6. LIST ANY OTHER PERTINENT INFORMATION CONCERNING THIS PROBLEM**

\_\_\_\_\_

\_\_\_\_\_

**7. HAS A PHYSICIAN DIAGNOSED YOUR HEADACHES? IF SO, WHAT WERE THE FINDINGS?**

\_\_\_\_\_

**8. APPLICANT**

**SIGNATURE**

**SOCIAL SECURITY NUMBER**

**DATE SIGNED**